VA Specialized Homeless Programs, Fiscal Year 2005

Background and Overview

"The oldest and strongest traditions of veterans care are based on the conviction that no civilized nation will turn its back on the poor, sick and homeless former soldiers who once relinquished civilian freedoms to serve their country. From the first veterans homes, Les Invalides in Paris and Chelsea Naval Hospital in England, established at the end of the 17th Century, through the founding of the United States Veterans Homes after the Civil War, and the expansion of the Department of Veterans Affairs' (VA) Department of Medicine and Surgery after World War II, sick, disabled and homeless veterans have received priority care. The [Homeless Chronically Mentally Ill] HCMI Veterans program, with its orientation towards community rehabilitation, merges this long tradition of care for sick and homeless veterans with a contemporary approach to service delivery for the disabled chronically mentally ill."

> ---Progress report on the Veterans Administration Program for Homeless Chronically Mentally Ill Veterans, October 22, 1987

Based on several scientific surveys showing that appreciable numbers of veterans were counted among homeless individuals and recognizing that the vast majority of homeless veterans suffer from serious medical and mental illnesses, VA implemented its first specialized programs for homeless veterans in 1986. Since that initial effort, VA has systematically developed the largest integrated network of services and programs designed to address the treatment, rehabilitation, and residential needs of homeless veterans. In fiscal year (FY) 2005, VA provided services to approximately 75,000 homeless veterans through its specialized homeless programs. VA specialized homeless services programs include the Domiciliary Care for Homeless Veterans Program (DCHV); the Compensated Work Therapy/Transitional Residence Program (CWT/TR); and Health Care for Homeless Veterans Program (HCHV) and its components (the Homeless Providers Grant and Per Diem [GPD] Program, the Supported Housing [SH] Program; and the Housing and Urban Development-Veterans Affairs Supported Housing Program [HUD-VASH]).

VA homeless services programs are designed to provide a continuum of care for homeless veterans. Key elements of this continuum are:

- *outreach* to identify veterans among homeless persons encountered in communities and *clinical assessment* to determine the needs of those veterans;

- *rehabilitation* in community-based contracted residential treatment (HCHV Program), VA domiciliary programs (DCHV Program) or transitional residences (CWT/TR Program);

- *supportive transitional housing* to facilitate community re-entry (for example, the Grant and Per Diem Program);

- *supportive case management* to maintain independent living in the community (for example, the SH and HUD-VASH Programs). This summary is organized around these broad service categories.

The development of VA's integrated service system for homeless veterans has been made possible through continued substantial support from Congress. In addition, funding allocations from VA's medical care appropriation have increased from approximately $21 million per year in 1987 and 1988 (the first years of the program) to approximately $174 million in FY 2005. Yet, even in the earliest stages of program planning and development, VA realized that no single organization could fully meet the multiple and varied needs of homeless veterans.

VA sought assistance from other Federal agencies and community-based organizations, including veterans' service organizations. Over time, VA has strengthened its alliances with the community by conducting ongoing needs assessment (via the Community Homelessness Assessment, Local Education and Networking Groups [CHALENG]), by contracting for residential treatment and by awarding grants to community service providers (via the Homeless Providers Grant and Per Diem Program). Today, VA and its partners provide a full continuum of care that ranges from aggressive outreach to permanent housing coupled with ongoing clinical case management.

The progress of VA's initiatives and partnerships has been documented by ongoing and integrated program evaluation. VA established the main organization for the evaluation of its homeless programs, the Northeast Program Evaluation Center (NEPEC), at the same time the first specialized clinical programs were initiated. NEPEC data, which document results of community outreach, residential treatment, and case management services, ensure accountability of these programs and have guided the development of new initiatives. In recent years, monitoring of and accountability for the delivery of clinical services to homeless veterans in both specialized homeless programs and in primary care and mental health programs have been incorporated into the performance plans of the Veterans Health Administration (VHA) leadership, further increasing the accountability of these programs.

Homelessness among veterans is a persistent problem that demands a comprehensive set of coordinated services. As the world's largest health care system, VA has dedicated significant resources to address the problem of homelessness among veterans. The descriptions of the program components that follow highlight this coordination and suggest a high level of service to this deserving population.

Community-Level Needs Assessment and Planning

Since 1993, VA has collaborated with local communities across the United States in Project CHALENG for Veterans. The spirit of CHALENG is to empower local communities to help homeless veterans regain their health (mental and physical), re-build meaningful interpersonal relationships (including family reunification), secure employment and stable housing, and ultimately return to their rightful place in society as respected, productive citizens. The main vehicle for coordinating these efforts is an annual meeting (or series of meetings) of VA and non-VA homeless service providers, as well as homeless veterans in each community to discuss service needs of homeless veterans. Action plans are developed during the meetings. The outcomes of these meetings and subsequent action plans are documented through a survey of participants, and results are summarized in a national annual report. In 2005, there were 4,321 respondents to the Participant Survey. Of the 4,321 participants, 907 (21 percent) were currently or formerly homeless veterans.

Long-term housing, child care, and dental care were the top unmet needs reported by 2005 CHALENG respondents which included homeless veterans, community and local government representatives and VA staff. These were the top unmet needs in the past four years as well. Fifty-six CHALENG sites reported new permanent housing units being secured, opened or under construction. Also, 12 sites credited VHA Directive 2002-080 in promoting greater access to VA dental care for homeless veterans. Regarding childcare, two sites reported homeless veterans receiving childcare services through new collaboration agreements with community programs.

In addition to ranking the needs of homeless veterans in the community, the development of services is documented. For example, 420 new interagency collaboration agreements were developed in 2005, and 232 new outreach sites were served. Nationwide, there were increases in (emergency, transitional, and permanent combined) housing that homeless veterans can access. Thanks to these new interagency collaboration agreements, 1138 additional homeless veterans received mental health/substance abuse treatment, 349 additional homeless veterans received eye care, and 846 additional homeless veterans received dental care.

CHALENG is an integral part of VA's homeless services program. Through regularly scheduled CHALENG meetings, VA medical centers have strengthened their partnerships with community service providers. This has led to improved coordination of services and the development of innovative strategies to address the needs of homeless veterans.

Outreach Services

HCHV Program. The first core component of VA homeless services is outreach services. In 1987, VA started the first HCMI Veterans Programs at 43 VA medical centers across the country. The program is now called the Health Care for Homeless Veterans Program (HCHV) and operates at 132 medical centers. A core component of the program is to provide outreach to, and clinical assessment of, homeless veterans living on the streets and in emergency shelters. The mission for this program is to locate homeless veterans who have serious psychiatric and substance abuse problems and connect them with needed mental health, medical, and rehabilitative services.

In FY 2005, there were 330 program clinicians (mostly social workers and nurses) dedicated to the HCHV outreach effort. These clinicians contacted 40,568 homeless veterans (127 veterans per clinician). This is a decrease of approximately five percent from the number of contacts in FY 2004 (42,688), and a 13 percent decrease from the number of assessments conducted in FY 2001 (46,759).

About 96 percent (39,026) of the veterans contacted in FY 2005 were male, and their average age was 49.6 years. About 47 percent (19,148) of the veterans assessed were African American. About 44 percent (17,848) of these veterans served in the military during the Vietnam era. Nearly 62 percent (25,152) of the veterans seen were living in shelters or in outdoor locations at the time of first contact, and 39 percent (15,699) had been homeless for 6 months or more. Of the veterans contacted, approximately 83 percent (33,671) had a serious psychiatric or substance use disorder and 38 percent (15,415) had both psychiatric and substance use disorders. Over three quarters (30,263) of these veterans had not worked in the 30 days just prior to assessment; about 60 percent (24,503) had a monthly income of less than $500.

The main outcome of clinical outreach is to connect homeless veterans with needed services, especially mental health services. Through linking of clinical assessment data with VA administrative databases, it was shown that approximately 76 percent (30,750) of the veterans contacted at outreach during FY 2005 received VA mental health services (including direct services provided by the HCHV program) in the 6 months following outreach. Almost half (47.5 percent) of the veterans contacted at outreach (19,269) had not used any VA mental health services in the 6 months prior to outreach.

These data indicate that the HCHV outreach program is successful in locating homeless veterans who have psychiatric and substance abuse problems and connecting them to needed mental health services.

Compensation and Pension Service (C&P). There is at least one full-time homeless veterans outreach coordinator (HVOC) at the 20 regional offices with the largest homeless veteran population. As follows:

Atlanta	Detroit	Nashville	Philadelphia	St. Louis
Boston	Houston	Newark	Phoenix	St. Petersburg
Chicago	Indianapolis	New York	Roanoke	Waco
Cleveland	Los Angeles	Oakland	Seattle	Winston-Salem

Coordinators are assigned at all other VA regional offices on a full or part-time basis. In assisting homeless veterans, HVOCs and other regional office staff made 4,247 contacts with shelters for the homeless in FY 2005. During the same period, their referrals to VHA and the Department of Labor's Jobs for the Homeless Program totaled 7,416, they made 4,803 referrals to other community support or social service agencies, and they were contacted by homeless veterans for assistance 34,631 times. The number of referrals to other community support or social service agencies increased in FY 2005 compared to FY 2004, while activities in all other categories decreased. They also participate in all stand downs in their jurisdictions. VBA's program manager for outreach to homeless veterans is on the Compensation and Pension Service staff, and serves as a resource for information and assistance to HVOCs.

As a training opportunity, VBA continued to sponsor attendance of the HVOCs at the Annual National Coalition for Homeless Veterans conference in May 2005. In addition HVOCs participate in NCHV periodic telephone conference calls. Additional training is offered through Compensation and Pension Service quarterly conference calls with VBA HVOCs. The Compensation and Pension Service's program manager for homeless veterans outreach routinely e-mails HVOCs pertinent information including notices from VA's Homeless Programs Office, NCHV, DOL's National Veterans Training Institute, etc. Training materials and information are also available on the Compensation & Pension Service Intranet web page for Homeless Veterans Outreach Coordinators. Compensation and Pension Service continues to encourage HVOC liaison and networking with VA medical center homeless program coordinators and community providers including those sponsored or supported by the VA health care system.

In October 2003, the directors of 10 regional offices were directed to join the executive committee of their area's Regional Council of the Interagency Council on Homelessness. They were selected based on their proximity to each of the ICH Regional Council's base city. The HVOC for each of those offices was instructed to join their ICH region's working group as well. Since then, other regional offices' HVOCs became active and are now working with their city's officials and working groups in their plan to end chronic homelessness in 10 years.

VBA operates on longstanding procedures to expedite the processing of homeless veterans' claims – with a goal of 30-day processing. A reporting procedure was developed to capture actual homeless veteran claims received beginning on October 1, 2003. The following data is provided for FY 2005:

7,678	Compensation claims were received.
6,144	Pension claims were received
13,822	Total Compensation & Pension claims were received

37%	Compensation was granted (of claims finalized)
73%	Pension was granted (of claims finalized)

149	Average pending days on Compensation claims *granted*
152	Average pending days on Compensation claims *denied*
152	Average pending days on Compensation claims *pending*

90	Average pending days on Pension claims *granted*
105	Average pending days on Pension claims *denied*
112	Average pending days on Pension claims *pending*

44.20%	Average disability rating when Compensation granted (286 cases were rated 100%)

VA regional offices continue to be proactive in their mission to assist homeless veterans, and they are involved in the Department of Labor (DOL) and VA joint pilot programs for transitioning incarcerated veterans back to the community. The Denver Regional Office (RO) works closely with the Colorado Department of Labor and Employment and the Colorado Department of Corrections pilot programs sites at state prison facilities. The RO HVOC verifies eligibility for each veteran inmate who applies for the program to ensure they are eligible for VBA or VHA benefits. Benefits information and claims assistance are also provided to the veterans. The Philadelphia RO along with staff from the VAMC in outreach to incarcerated veterans met with officials from the Pennsylvania State Correctional Institute (SCI). They developed a handbook for SCI personnel to use as a guide to assist incarcerated veterans. In addition to the HVOCs in Denver and Philadelphia, the HVOC in St. Louis met with the St. Patrick's Center to learn how the VA can assist the center with their grant to counsel incarcerated veterans. The St. Patrick's Center is one of the 30 recipients who recently received a grant under the DOL's Prisoner Re-entry Initiative. Other ROs' HVOCs provided veterans benefits information to the Heart of Texas Homeless Coalition (Waco), the El Paso Coalition for the Homeless, and other veterans service providers.

Unfortunately, the remains of deceased homeless veterans are sometimes unclaimed. VBA's Burial of Unclaimed, Indigent Veterans Program provides

information on how an unclaimed person may be identified as a veteran and the burial benefits that may be available. An Internet web site was established for that program and can be found at http://www.vba.va.gov/bln/21/Topics/Indigent/index.htm. Each regional office has a designated coordinator for the program. On a national level, Compensation and Pension Service officials continue to work with the National Funeral Directors Association (NFDA) and the National Association of Medical Examiners to improve VBA's outreach and to prevent unclaimed, indigent veterans from being buried in pauper graves. The Center for Disease Control and the NFDA has linked our Web site to theirs. On the local level, interaction has been established with funeral directors as well as county/state coroners and medical examiners.

Residential Treatment

A second core component of VA homeless services is residential treatment. Residential treatment programs provide safe housing that has continuous staff supervision, are designed to reinforce abstinence from substances, and provide on-site psychosocial counseling and ongoing case management. In the HCHV Program, these services are contracted from non-VA providers; in the DCHV and CWT/TR Programs, VA staff provides these services. Residential treatment has been part of the HCHV and DCHV Programs since their initiation in 1987; the CWT/TR Program was started in 1990. While in residential treatment, veterans may participate in the Veterans Industries/Compensated Work Therapy (VI/CWT) Program, which offers a wide range of rehabilitation services, ranging from formal evaluation and counseling to remunerative work and training experiences.

HCHV Contract Residential Treatment. FY 2003 marked the beginning of a transition in the delivery of VA's residential treatment and transitional housing services. Specifically, a planned phase out of centralized funding for contract residential treatment was initiated, concurrent with augmentation of funding for VA's Homeless Providers Grant and Per Diem program (see "Transitional Housing" section below). FY 2005 was the second full year that all contract residential treatment in the HCHV program was supported by network or local medical center funding. Several networks continued to fund contract residential treatment and approximately $6.2 million was spent on contract residential treatment services, a decrease of about 15 percent relative to FY 2004 funding levels ($7.3 million).

These local funds supported 1,725 episodes of residential treatment in community-based halfway houses during FY 2005; the number of episodes of treatment decreased by 20 percent from the number in FY 2004. The overwhelming majority of veterans placed in contract care during FY 2005 (86 percent or 1,034) met all of the appropriate criteria for residential treatment (homelessness, low income, and clinical need). The average length of stay in the program was 64 days, and the average cost per episode was $2,266.

About 57 percent (985) of the veterans discharged during FY 2005 were judged to have successfully completed residential treatment. Forty-nine percent (847) had an apartment, room, or house at discharge, and an additional 37 percent (635) were discharged to another treatment setting (such as a halfway house). Less than 2 percent (29) of veterans discharged from residential treatment were known to return to homelessness. Approximately 48 percent (819) had part-time or full-time employment (including employment through the VI program). Clinical gains were substantial: about 70 percent (1,208) experienced improvement at the time of discharge. Monitoring of mental health outpatient encounters indicated that 69 percent (1,190) of discharged veterans were followed up with some type of VA after-care services within 30 days of discharge.

HCHV residential treatment continues through funding by networks and medical centers. Although the number of veterans served by this program is less than years when funding was centralized, the data demonstrate that this program continues to provide a wide range of effective services to an appreciable number of homeless veterans.

DCHV Residential Treatment. Residential rehabilitation and treatment is currently offered through Domiciliary Care for Homeless Veterans (DCHV) programs at 34 VA medical centers. The DCHV program is part of the larger Domiciliary Residential Rehabilitation and Treatment Program (DRRTP). There are 1,833 beds dedicated to the treatment of homeless veterans, the same number as the previous fiscal year. During FY 2005, 5,394 veterans completed an episode of DCHV treatment. Monitoring data indicate that the DCHV program serves a veteran population with a high prevalence of substance abuse disorders. Nine out of ten veterans (92 percent or 4,962) were diagnosed with a substance abuse disorder, exactly half (50 percent or 2,697) had a serious mental illness (e.g., schizophrenia, bipolar disorder, anxiety disorders including post-traumatic stress disorder (PTSD), and major affective disorders) and 46 percent (2,481) were dually-diagnosed with a psychiatric disorder and a substance use disorder. During FY 2005 the average length of stay was 108.7 days, slightly less than the prior fiscal year. Lengths of stay had dropped by nearly 37 days between FY 1995 and FY 2000, but have remained between 107 – 115 days from FY 2001 to the present.

Of the total number of veterans discharged during FY 2005, 36 percent (1,942) were discharged to their own apartment, room or house; an additional 25 percent (1,348) were discharged to an apartment, room or house of a family member or friend. Almost one-fourth (23.8 percent or 1,284) were discharged to an institution, another DRRTP, or transitional housing. At discharge, 36 percent (1,942) had arrangements to work in part-or full-time competitive employment, while an additional 15 percent (809) had arrangements to participate in a VA work therapy program.

CWT/TR Residential Treatment. The Compensated Work Therapy Transitional Residence (CWT/TR) program is currently in its fifteenth year of operation. From the program's inception in September 1990 to the end of FY 2005 there have been over 7,800 admissions and 7,100 discharges. Originally implemented in 1990 as a 14-site program with 236 beds, the CWT/TR program has expanded to 42 sites with 33 operational programs and 510 operational beds at the end of FY2005. Currently 16 of the 33 CWT/TR programs have a primary mission of treating veterans with substance use disorders, 12 programs are designed to treat veterans who are homeless and have a mental illness, 3 sites treat veterans with a mental illness who also have vocational deficits, and 2 sites are designed to treat veterans with PTSD.

The program is reaching its intended target population. Virtually every veteran carries a clinical psychiatric diagnosis. Of the 674 veterans admitted in FY 2005, 93 percent (627) had a substance use disorder, 52 percent (350) had a serious psychiatric diagnosis (e.g., schizophrenia, bipolar disorder, anxiety disorder including posttraumatic stress disorder (PTSD), or major affective disorder) and 47 percent (317) were diagnosed with both a substance use disorder and a psychiatric disorder. Additionally, 77 percent of veterans (519) reported being homeless at least once in their lifetime and 52 percent (350) of veterans reported being homeless when they last lived in the community.

The CWT/TR program is a national network of therapeutic community residences that provide active rehabilitation. The work program offers multiple vocational options including transitional employment, and supported employment is increasingly available for those veterans with a severe mental illness. In FY 2005, veterans earned, on average, $166 per week – more than enough to cover the weekly rent of $51. During FY 2005 the mean length of stay in the program was approximately 6 months (175 days).

Upon discharge, 52 percent (332) of veterans were judged to have successfully completed the program, 40 percent (259) had arrangements to work in competitive employment, and 74 percent (473) had arrangements to live in an apartment room or house.

Outcome data indicate that veterans are substantially better off in the 3 months after discharge from the program when compared to the 3 months prior to admission. Clinical improvement was noted on virtually all outcome measures, most importantly in substance abuse (68.0 percent reduction in alcohol problems and a 78.6 percent reduction in drug problems); psychiatric problems (20.6 percent reduction); employment (over 1200 percent increase in days worked); income (101.4 percent increase in total monthly income); housing status (166.7 percent increase in days housed, 77.8 percent decrease in days institutionalized and a 50.1 percent decrease in days homeless); as well as in number of social contacts (20.9 percent increase).

These data are encouraging, although they may be biased due to incomplete data: the overall 90-day post discharge follow-up rate in FY 2005 was 52 percent. Follow-rates have generally declined over the years as a result of staff reductions.

Transitional Supported Housing

Homeless Providers Grant and Per Diem Program. A third core component of VA homeless services is transitional supported housing. Under the GPD Program, VA offers grants to non-VA organizations to help develop supportive housing programs and supportive service centers. Non-VA organizations are also awarded grants to help purchase vans to conduct outreach and provide transportation for homeless veterans. Under the grant component of the program, VA can pay up to 65 percent of the total cost of the project. Once projects are complete, VA can provide per diem payments to help offset operational expenses of the program. In FY 2005, the per diem payment limit was $27.44. As mentioned in the previous section, in FY 2003 a portion of the centralized funding of HCHV contract residential treatment was shifted to the GPD program; GPD is the primary resource for transitional housing and residential treatment among the VA homeless programs.

Since 1994, VA has offered grants totaling $85 million to help create over 6,600 new community-based beds for homeless veterans. It should be noted that historically there has been a 10 percent attrition rate for capital grant funded beds. To date, over 4,500 beds have been developed with grant funds and are now operational and receiving per diem payments from VA. The remaining beds are expected to become operational in the next 2 to 3 years.

In FY 2000, VA offered the first Per Diem Only (PDO) Notice of Funding Availability. The intent of this funding was to assist eligible entities that already had facilities or were willing to construct/renovate facilities at their own costs, in developing supportive housing programs specifically for homeless veterans by paying them per diem to help offset operational expenses. Funding for the original PDO awards expired in FY 2002. In FY 2002, 2003 and 2004, VA awarded 3-year funding for three new rounds of PDO programs which will support the operation of approximately 3,200 beds. In FY 2005 VA gave proven PDO programs the opportunity to renew their PDO funding for as long as the GPD program is reauthorized and they are in compliance with all funding requirements.

Together, grant-funded and PDO initiatives provided approximately 7,700 operational beds in FY 2005. The mission of the service providers varies widely, ranging from residential treatment to transitional housing with little or no clinical support services.

The main referral source to GPD housing is the HCHV Outreach Program. Therefore, the characteristics of the veterans in the GPD Program are similar to the larger outreach population: high prevalence of poverty, unemployment, and serious medical and mental health problems.

There were 15,403 discharges from GPD in FY 2005. The average length of stay overall was about 127 days; however there is considerable variability across sites. This is to be expected, as the missions of the programs are widely variable. Data indicate that 50 percent (7,701) of the veterans in GPD stay 72 days or less, with eight programs having a median length of stay of less than 30 days. In contrast, there are nine programs that have median lengths of stay over 6 months. The average cost per episode in the GPD program was $3,085 (median: $1,686).

During FY 2005, 50 percent (7,524) of the veterans were discharged successfully, which is about the same percentage as during FY 2004. Successful discharge is reported when the veteran has actively participated in accordance with treatment goals and the discharge is mutually agreed upon. A substantial portion of veterans were discharged due to program rule violations (20 percent; 3,010 veterans), or the veteran left the program without consultation (22 percent; 3,235 veterans). This may be a result of the wide variety of program types funded by GPD that include large bed capacity projects, emergency housing program designs, and projects where outreach is conducted by non-VA staff. About 54 percent (8,126) of homeless veterans discharged from GPD moved into independent housing; an additional 27 percent (4,063) were discharged to another treatment setting. These percentages have increased appreciably in the past three years. Approximately 38 percent (5,658) of veterans discharged were employed full-time, part-time or through VI. Between 55 and 70 percent (8,276 – 10,534) of the veterans (with a history of substance use, mental health, medical or social-vocational problems) were rated as having improved clinical status at discharge.

The GPD program continues to grow in regard to the number of programs providing services to veterans. Collectively, over 7,000 transitional housing beds are now available to homeless veterans with appreciable cost sharing by the community non-profit organizations in partnership with VA. The similarity of demographic characteristics between those veterans contacted by the GPD in comparison to the larger HCHV outreach population shows that referrals to the program are appropriate. Housing, and clinical improvement outcomes exceed those observed for contract residential treatment, in part because of the substantially longer length of stay in GPD programs.

The Homeless Veterans Comprehensive Assistance Act of 2001 (Pub. L. 107-95) directs the Department of Veterans Affairs to survey current programs established under VA's Homeless Providers Grant and Per Diem Program concerning their experiences in applying for and receiving grants form the

Department of Housing and Urban Development to serve primarily homeless persons. Recently 248 surveys were sent out to grant and per diem providers. Of these 106 were returned (a return rate of 43%). This is down 3% from last year's response rate of 46%. This is a second year of decline. Results of the survey show:

- 28 percent of GPD providers reported that they received technical assistance from HUD. This is a decrease of 5 percent from 2004's figure of 23 percent receiving technical assistance.

- Participation of GPD providers in the HUD Continuum decreased again in 2005 to 24 percent. This is a decrease of 12 percent from 2004's figure of 36 percent.

- Applications to HUD from GPD providers decreased for a third year in 2005 to 19 percent. This is a decrease of 20 percent from 2004's figure of 39 percent.

- The percentage of GPD providers receiving new HUD funding in 2005 decreased to 18 percent down from 23 percent in 2004. Note: This may be due to many programs securing multi-year funding in previous years.

- GPD providers reported $30,887,765.00 of HUD funding in 2005. This is roughly $4 M dollars more than what was received in 2004. Of these funds providers indicated that $6,927,401.00 was new funding and $23,960,364.00 was received in 2005 from previous multi-year awards.

- Programs reported using an average of 28 percent of the funding received to aid in supporting their veteran specific programs. This figure is an increase from 2004's figure of 24 percent.

- The percentage of veteran specific programs that have received funding increased in 2005. The figure reported was 41 percent, an increase of 6 percent from 2004.

Long-term Supported Housing

Supported Housing Program. The fourth component of VA homeless services is long-term supported housing. In FY 1993, VA established 26 SH Programs. The impetus for these programs was a finding from a study of VA homeless programs that 6-month outcomes for homeless veterans receiving case management were almost as good as for homeless veterans receiving residential treatment, and costs were substantially less. In the SH program, VA staff provide case management services and, as part of the ongoing clinical support, help homeless veterans secure long-term transitional or permanent

housing and help them remain in housing through the development of daily living skills.

SH case managers work within the HCHV team, therefore, virtually all of the veterans entering the SH program are initially contacted through HCHV outreach. In FY 2005, 19 SH programs actively case managed veterans; the total number of veterans who received case management was 1,255. The number of SH programs in operation has declined appreciably in the last three years. Some SH programs stopped admitting veterans to the program because SH clinicians' work was directed to the GPD program instead.

The demographic and clinical characteristics of SH clients match those of the larger outreach group. They have a very high rate of substance abuse and psychiatric disorders, and over one-third have been homeless for over 6 months.

Veterans in the SH Program live in various types of housing. The program strives to settle veterans into independent community housing. The average length of stay in the program is over a year; a few programs have appreciably longer lengths of stay. The median length of stay is about 10 months (313 days). About a quarter (313) of veterans in the SH program receive HUD Section 8 rental assistance. Overall, veterans paid an average rent of $266 monthly while in the SH Program.

Over half (58 percent; 235 veterans) of the 406 veterans discharged from this program during FY 2005 had a mutually agreed-upon termination, and 65 percent (264) moved to independent housing upon discharge. About 57 percent (232) were employed full-time, part-time or were in VI programs at the time of discharge from SH.

HUD-VASH Program. In 1992, VA joined with HUD to launch the HUD-VASH program. HUD-VASH was initiated to further the objectives of serving the homeless mentally ill veteran through two closely linked interventions: (1) a housing subsidy provided through HUD's Section 8 voucher program, and (2) a community-oriented clinical case management effort. The goal of the program is to offer the homeless veteran an opportunity to rejoin the mainstream of community life, to the fullest extent possible. The main features of HUD-VASH that distinguish it from the SH Program are the availability of rental assistance for program veterans, a more formalized screening procedure, the emphasis on movement into independent community residences, and a somewhat more intensive, longer-term case management model. The program was phased in during 1992 to 1995; it currently operates in 34 locations with clinical staff at nearby VA medical centers dedicated to providing ongoing case management services for homeless veterans who receive these vouchers.

Due in part to reduced access to Section 8 vouchers in recent years, clinical activity in the HUD-VASH program has declined. For example, on

average, the HUD-VASH program admitted 405 new veterans per year between FY 2000 and FY 2003; in contrast during FY 2004 only 172 new veterans were admitted to the program and during FY 2005 only 141 veterans were admitted. For the second straight year, 16 of the 34 HUD-VASH programs admitted no new veterans during FY 2005; another six programs admitted fewer than five veterans. Additionally, HUD-VASH has experienced more VA staff reductions than other VA homeless programs. Approximately 63 percent (47) of the 74 clinical case manager positions initially allocated to the program were filled in FY 2005.

Despite these program reductions, over 1,000 veterans were active in the HUD-VASH program during FY 2005. The case management offered by the program is very long term, and the turnover of vouchers is relatively low. Consequently, even at sites whose access to new vouchers was eliminated, veterans admitted to the program in previous years continued to receive case management.

The veterans admitted to the HUD-VASH Program share many of the same characteristics of the HCHV outreach population (which is the main referral source for HUD-VASH). HUD-VASH veterans tend to have spent more days homeless in the month before intake and the prevalence of serious psychiatric problems is somewhat higher in this group. Perhaps because of the flexible housing options available in HUD-VASH, the program admits more homeless women veterans than do other VA homeless programs.

The HUD-VASH Program excels at establishing veterans in their own apartments. Within 3 months of admission 72 percent (590) of 820 HUD-VASH veterans followed up were successfully housed. At the 18-month and 3-year intervals following admission to the program, the percentage of veterans housed is approximately 95 percent (based on 390 and 138 veterans followed up respectively). Although conclusions about outcomes at the 18-month and 3-year intervals have to be tempered in recognition of the appreciable attrition that occurs, these housing percentages compare favorably to other supported housing programs using HUD Section 8 vouchers.

Relative to time of entry into HUD-VASH, about 40 percent (312) of veterans improve their employment status, approximately 52 percent (426) improve their financial status, and about 58 (476) percent improve their living skills. Between 60 - 70 percent (492 - 574) of veterans improved on alcohol, drug and mental health problems at the same three follow-up intervals.

The HUD-VASH Program is a low-turnover, intensive case management program that provides stable independent housing for some of the most difficult-to-treat homeless veterans. The Section 8 rental assistance provided by HUD is a considerable resource for these homeless veterans.

New Homeless Program Initiatives

In FY 2000, VA's budget identified $39 million for programs providing direct services to homeless veterans. In October 2001, $11 million was retained as specific purpose funding to support the Grant and Per Diem Program and $28 million was moved into general medical care, at the recommendation of VHA's Policy Board. The Under Secretary for Health sent a memo to each Veterans Integrated Service Network (VISN) Director that outlined the expectation that each medical center within the VISN would continue to support the HCHV service programs created by these FY 2000 expansion funds at the original funding level for an additional 2-year period. Part of this funding enabled the creation of 66 new HCHV programs that conduct outreach and provide residential treatment as described above. Another part of the funding was used to develop new service programs for homeless veterans and to conduct studies of existing programs. These new initiatives were all designed to include a quasi-experimental longitudinal evaluation component to aid in determining effectiveness. Incorporation of a longitudinal evaluation into these new initiatives is part of the VA's response to a 1999 General Accounting Office review of VA homeless programs, which suggested such an evaluation.

Outreach to Homeless Women Veterans. Demonstration programs were funded at 10 VA medical centers to address the specialized needs of homeless women veterans and homeless women veterans with children. Services provided to these veterans included outreach; residential treatment; assistance in finding child care services; case management; referrals for psychiatric and substance use disorder treatment; referrals for gynecological and other medical care and assistance with long-term permanent housing. In addition, a new psychotherapeutic model called "Seeking Safety" was implemented to help homeless women veterans who suffer from trauma, mental illness, and substance use disorders. Developed by Dr. Lisa Najavits of Harvard University and used successfully in the private sector, this treatment approach helps patients develop healthy relationships, understand concepts of personal safety, recognize dangerous situations, and learn skills to stop self-harm behavior.

The program was evaluated by a longitudinal pre-post cohort study. A pre-implementation cohort (Phase I) (N=359) was recruited at the 11 sites before Seeking Safety was implemented and a post-implementation cohort (Phase II) (N=91) was recruited after implementation and offered Seeking Safety treatment, primarily in a group therapy model.

Women entering the program, regardless of which phase they were in, showed significant improvement on clinical outcome measures. The Seeking Safety group, who received on average 12 sessions of Seeking Safety, reported significantly better outcomes over one year in the areas of days worked, social support, psychiatric symptoms and symptoms of PTSD, particularly hyper-

vigilance and avoidant behavior. On other measures of outcome such as self-esteem, perceived mental and physical health scores, and substance use, the Seeking Safety group reported equivalent outcomes to the Phase I women. In general, Phase I women received more practical services from VA case managers (e.g. supportive contact, help obtaining housing, making referrals to care) while Phase II women received more substance abuse counseling and psychotherapeutic care).

A full report on the Homeless Women Veterans' program study was submitted to VA Central Office in March, 2006.

Critical Time Intervention Case Management. Demonstration programs were funded at eight VA medical centers to implement the Critical Time Intervention (CTI) case management model, developed by Drs. Ezra Susser and Alan Felix of Columbia University. The CTI is a case management model for hospitalized seriously mentally ill homeless veterans who have sought VA treatment on their own. These veterans have high rates of recidivism, a low quality of life, and utilize a disproportionate number of mental health bed days of care. This program sought to reduce the recurrence of homelessness in this population through intensive case management and support during the transition between institutional and community living. Veterans enrolled in the program received CTI services for approximately 6 months, followed by usual community care. The program was evaluated by a longitudinal pre-post cohort study. A pre-implementation cohort (Phase 1; n=278) was recruited before CTI was implemented and a post-implementation cohort (Phase 2; n=206) was recruited after implementation and offered CTI.

Measures of service delivery show that CTI provided relatively intensive case management services for an average duration of about seven months and that the majority of case management clients ended case management in a planned manner. Controlling for baseline differences, clients in Phase 2 had 17.7 percent more days housed per 3-month period on average over the one-year follow-up (42.6 vs. 36.2 days; p=0.002) and 21.9 percent fewer days in institutional settings (20.3 vs. 26.0 days; p=0.003). Veterans in Phase 2 also had lower alcohol use (17.6 percent, p=0.001); lower drug use (14.3 percent, p=0.004) and fewer reported psychiatric problems (10.0 percent, p=0.001). No benefit of CTI case management was observed in the areas of employment or income.

A full report on the CTI study was submitted to VA Central Office in March, 2006.

Therapeutic Employment, Placement and Support. Research has demonstrated the therapeutic effectiveness of supported employment (which provides individualized support to clients in finding and keeping mainstream community jobs). The Individual Placement and Support model of supported

employment, developed by Robert E. Drake, M.D., Ph.D., and Deborah Becker, M.Ed., was adapted and implemented at 10 VA medical centers, which were given funds and on-site training to provide Supported Employment (SE).

To evaluate the effectiveness of SE among homeless veterans entering VA treatment, a non-equivalent control group study design was used. Before the SE worker was hired and trained each site recruited about 30 homeless veterans who expressed a desire to work, to participate in a 2-year follow-up study (N = 308). After the program was implemented another 30 veterans who expressed interest in employment were offered participation in SE (n=323). Thus, a total of 609 individuals were enrolled into the demonstration project during the recruitment period beginning January 1, 2001, and ending September 30, 2003.

At baseline, veterans in the second (SE) cohort had less severe psychiatric symptoms, were more likely to have been employed full- or part- time during the previous 3 years, and showed greater interest in supported employment. However, there were no differences in days of employment, hours worked, or earnings during the month prior to program entry. Of veterans offered SE, 80 percent (258) participated for 2 years and fidelity ratings showed good fidelity to the evidence based model at all but one site. After adjustment for potentially confounding factors, veterans in the second (SE) cohort worked 65 percent more days per month in competitive employment ($p<0.001$), and had higher total income ($p<0.05$), greater social support ($p=.008$) and more days housed ($p=.07$).

These findings demonstrate the feasibility of disseminating SE in VA and the effectiveness of a structured training model. As part of its response to the President's New Freedom Commission on Mental Health, VHA began the process of planning near the end of FY 2004 to disseminate this model to 21 mentor sites in FY 2005, one in each VISN, who will disseminate it to the other facilities in their VISNs in FY 2006 under guidance from VA Central Office.

A full report on the TEPS study was submitted to VA Central Office in March, 2006.

Evaluation of Residential Treatment Modalities. During FY 2002, NEPEC launched a follow-up study on the outcomes, cost effectiveness, and role of aftercare in three approaches to residential treatment for homeless veterans. The study ended enrollment in November, 2004 with 1,349 veterans (99.9 percent of the enrollment goal) who were served either in DCHV, HCHV, or Grant and Per Diem funded residential care at five sites nationally – Cleveland-Cincinnati; Greater Los Angeles; Philadelphia; Tampa-Bay Pines-Miami; and Washington DC-Martinsburg-Baltimore. Over the course of the study, interviewers have followed and interviewed study veterans for one year after their discharge from VA-funded residential care. The study officially ended follow-up

interviewing of the veterans on September 30, 2005. As of September 30, 2005, 1,296 (96 percent of enrolled study participants) had been discharged from residential care and had been followed for post-discharge interviews. Percentages of veterans successfully interviewed for follow-up averaged 77 percent across the four follow-up interview time points (at 1, 3, 6, and 12 months following residential care discharge) and 79 percent were interviewed for the 12 month follow-up. Preliminary analyses of the data indicate that 80 percent of the veterans receiving residential care services through the three programs – DCHV, HCHV, and Grant and Per Diem – were housed at the one-year follow-up. Detailed data analyses of final data are expected to be completed by July, 2006.

Summary

Homelessness is a complex issue. Services to homeless individuals are integral to the care of those individuals who served our Nation in the military and now find themselves among the Nation's most disadvantaged. As the largest single provider of direct services to homeless veterans, VA will continue to address the problems of this particular group through its wide range of specialized programs.